



# NO SUB AUTHORIZATION REQUEST

Fax Requests to 905-949-3029

OR Mail Requests to Clinical Services, ClaimSecure Inc., Suite 620, 1 City Centre Drive, Mississauga, Ontario, L5B 1M2

## TO BE COMPLETED BY PATIENT

Plan Member		Group Number		Certificate Number	
Patient Name		Relationship to Member Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/>		Street Address	
City	Province	Postal Code	Telephone Number ( )	Patient Date of Birth (YYYY/MM/DD)	

If you would like to receive a response/letter via email, please write your email address clearly to ensure accuracy otherwise, we will reply by mail.

OR If you are registered with eProfile and would like your response/letter sent to you by email, please check "yes" below and we will use the email you provided for your eProfile account.

- Yes, please email the response/letter to the email I provided in my eProfile account.
- No, I do not wish to receive an email response at this time.

Please be advised, all response/letters that are emailed will not be followed by a mailed response.

I hereby authorize:

1. Any physician, hospital, insurance company, other healthcare professional, and ClaimSecure to exchange information in connection with this claim for the purpose of special authorization – patient exception evaluation, adjudication of claims, and administration of my health benefit program.
2. The exchange of information between patient assistance program administration companies and ClaimSecure for the purpose of ensuring continuity of care by locating, initiating and monitoring additional coverage or reimbursement assistance.

I assume responsibility for any cost required for the completion of this form. A photocopy of this authorization shall be as valid as the original.

Signature <b>X</b>	Date (YYYY/MM/DD)
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## TO BE COMPLETED BY PHYSICIAN

Physician Name		Specialty Qualification		Date (YYYY/MM/DD)	
Street Address			Physician Signature <b>X</b>		
City	Province	Postal Code	Telephone Number ( )	Fax Number ( )	

## DRUG REQUESTED FOR NO SUBSTITUTION

Diagnosis

Product Name

## INTERCHANGEABLE GENERIC DRUGS TRIED – MUST USE TWO GENERICS IF AVAILABLE

Generic Product Name (1)

Please select the applicable medical reason why the above generic drug cannot be used by patient:

- Contraindication                       Adverse Reaction                       Therapeutic Failure

Please specify the effects:

Generic Product Name (2)

Please select the applicable medical reason why the above generic drug cannot be used by patient:

- Contraindication                       Adverse Reaction                       Therapeutic Failure

Please specify the effects:

Additional Comments:

Approved Yes <input type="checkbox"/> No <input type="checkbox"/>	Effective Date (YYYY/MM/DD)	Expiry Date (YYYY/MM/DD)	Reviewer
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